BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **CHUCK S. MANGUBAT, M.D.** Holder of License No. 24330 For the Practice of Allopathic Medicine In the State of Arizona	Case No. MD-05-0515A **CONSENT AGREEMENT FOR LETTER OF REPRIMAND**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Chuck S. Mangubat, M.D. ("Respondent"), the parties agreed to the following disposition of this matter.

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter.

2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. The Board may adopt this Consent Agreement of any part thereof. This Consent Agreement, or any part thereof, may be considered in any future disciplinary action against Respondent.

5. This Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any waiver,

express or implied, of the Board's statutory authority or jurisdiction regarding any other pending or future investigation, action or proceeding. The acceptance of this Consent Agreement does not preclude any other agency, subdivision or officer of this State from instituting other civil or criminal proceedings with respect to the conduct that is the subject of this Consent Agreement.

6. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

7. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

8. If the Board does not adopt this Consent Agreement, Respondent will not assert as a defense that the Board's consideration of this Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.

9. This Consent Agreement, once approved and signed, is a public record that will be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Arizona Medical Board's website.

10. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and effect.

11. Any violation of this Consent Agreement constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451.

CHUCK S. MANGUBAT, M.D.

DATED: 1-3-2007

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 24330 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-05-0515A after receiving a complaint regarding Respondent's care and treatment of a sixty-three year-old male patient ("JF").

4. On February 13, 2005 JF presented to the hospital emergency department complaining of confusion and agitation for several days. The examining physician ordered a computed tomography scan of JF's head and a complete blood count. Both tests were normal. However, the blood count revealed a serum sodium level of 121 – well below the normal range for sodium. The physician considered a diagnosis of hyponatremia and, on February 14, 2005, ordered a chest X-ray to determine if there were any hyponatremic associated abnormalities on JF's lungs. The X-ray was completed at 8:18 a.m. and read and dictated at 3:50 p.m. by the radiologist, but was not transcribed until February 16, 2005.

5. On February 14, 2005 JF was admitted to the hospital under Respondent's care in the absence of the regular attending physician. Respondent documented little information in the hospital record regarding what transpired between him and JF during JF's hospital stay. On February 15, 2005 Respondent discharged JF before the X-ray results were available, referred him to behavioral counseling for alcohol abuse and advised him to follow up with his primary care physician ("PCP"). Respondent did not mention the pending chest X-ray results nor that a lung problem could be the cause of the hyponatremia.

6. JF subsequently obtained his hospital medical records, discovered the abnormal X-ray results, and pursued follow up care with his PCP. JF was diagnosed with lung cancer and hyponatremia secondary to syndrome of inappropriate antidiuretic hormone ("SIADH").

7. On July 12, 2005 Respondent was informed the Board had received a complaint and was investigating the care Respondent rendered to JF. On August 16, 2005 Respondent dictated a discharge report (six months after he discharged JF) stating he informed JF that alcohol consumption was most likely contributing to the hyponatremia as well as, and "more importantly," SIADH that is commonly associated with "undiagnosed pulmonary malignancy." Respondent also reported that he informed JF of the importance of the pending X-ray, particularly as a smoker, and that he should follow up with his primary care provider for further evaluation. There is no evidence in the record, other than this discharge report, that Respondent followed up with JF regarding the abnormal X-ray results.

8. The standard of care requires a physician to adequately follow up on all tests pertaining to a diagnosis and to inform the patient of those findings.

9. Respondent deviated from the standard of care because he did not follow up on JF's X-ray and failed to inform JF of the X-ray results.

10. Respondent's failure to follow up on the X-ray results delayed the diagnosis of lung cancer and caused a corresponding delay in treatment, potentially worsening JF's outcome.

11. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another

practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because he failed to timely dictate his discharge summary report.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e)("[f]ailing or refusing to maintain adequate records on a patient;") A.R.S. § 32-1401(27)(q)("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public;") A.R.S. § 32-1401(27)(ll)("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient;") and A.R.S. § 32-1401(27)(t) ("[k]nowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an application for privileges at a health care institution.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand for failing to follow up on and inform the patient of X-ray results, for making a false statement in the medical record, and for failing to maintain adequate patient records.

2. This Order is the final disposition of case number MD-05-0515A.

DATED AND EFFECTIVE this 9th day of February, 2006.7

(SEAL)

ARIZONA MEDICAL BOARD

By _____
TIMOTHY C.MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 9th day of February, 2006.7 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed this 9th day of February, 2006.7 to:

Gary A. Fadell Esq.
Fadell Cheney & Burt PLLC
1601 N 7th St Ste 400
Phoenix AZ 85006-2296

EXECUTED COPY of the foregoing mailed this 9th day of February, 2006.7 to:

Chuck S. Mangubat, M.D.
Address of Record

_____
Investigational Review